LIVERPOOL
SAFEGUARDING
CHILDREN
BOARD

LEARNING & IMPROVEMENT FRAMEWORK (LIF)

Last amend June 2016

Introduction

Responsibility of the Local Safeguarding Children Board

Working Together to Safeguard Children (2013: 65) requires that all Local Safeguarding Children Boards maintain a local Learning and Improvement Framework (LIF).

This Learning and Improvement Framework should

'enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.'

Working Together requires that the local framework should '*cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.'*

The LSCB Learning and Improvement framework has been developed to ensure that LSCB partner organisations and agency individuals are clear about what needs to be learnt, where services and practice improvement is required and how any programme of action will lead to sustainable improvements. Integral to the success of this framework will be the sharing of learning on a wide area basis to ensure transparency, accountability and consistent improvement to practice.

Learning and reviewing opportunities in Liverpool will be transparent so that they identify promptly the need for any systemic or organisational changes and ensure timely action is taken. This will ensure that professionals, in all services working with children and families, are given the assistance they need so that they can undertake the complex and difficult work of protecting children with confidence and competence.

The processes highlighted within this framework, including those used for learning, the findings from reviews and improvement activity initiated, are intended to provide assurance to children, families and other relevant stakeholders of the activity, undertaken by the partnership of LSCB, to improve the effectiveness of safeguarding services in Liverpool.

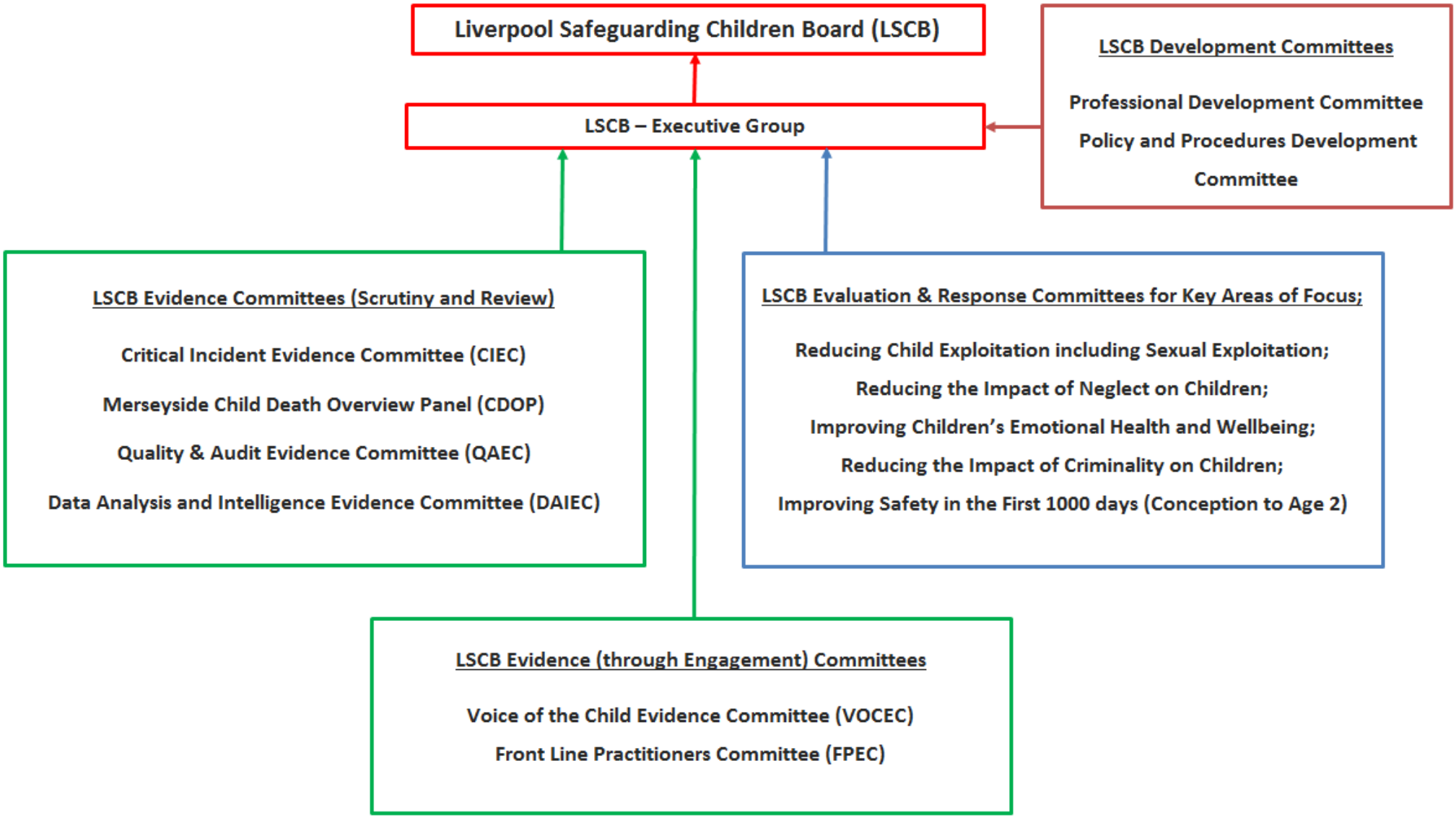
Responsibility of Organisations

All single agencies/partner organisations should ensure that they are aware of the findings from local reviews that are made available from Liverpool Safeguarding Children Board and should use this Learning and Improvement Framework to inform Single agency Learning and Improvement activity.

Responsive Learning

LSCB's LIF is updated on a regular basis. It is a responsive document and should be reviewed by organisations, practitioners and all staff regularly so they fully understand of current learning to inform practice.

Liverpool Safeguarding Children Board (LSCB) - Organisational Structure 2016/17 (01.04.16)



Principles for Learning and Improvement

The following principles outline the outcomes Liverpool LSCB and partner agencies should achieve through the process of conducting case reviews, practitioner forums and audits. These outcomes will be placed in the context that any system, including safeguarding systems can only manage and reduce risk, not eliminate it and that systems are made up of numerous variables that constantly change and fully appraising and managing risks of each variable is a complex task.

- There should be a culture of ***continuous learning and improvement*** across organisations, identifying opportunities to draw on what works and promote good and effective multi-agency practice;

- Learning and reviewing methods recognise the complex circumstances in which professionals work together to safeguard children – as much effort in the process of reviewing should go into identifying and analysing areas of good practice as well as practice that requires improvement;

- Learning and reviewing methods are transparent in the way they collate and analyse data and make use of research and evidence to inform findings;

- The approach taken to learning and reviewing should be proportionate to the scale and complexity of the issues being examined;

- Professionals must be involved in learning and reviewing opportunities; contributing their perspectives without a fear of being blamed for actions taken in good faith;

- Families, including children (where possible) should be invited to contribute in learning and reviewing opportunities; there should be clarity of how they will be involved and their expectations should be managed appropriately and sensitively;

- Serious Case Reviews should be led by one or more persons who are independent of the case being reviewed and the organisations whose actions are being reviewed;

- There is transparency with professionals, family and the public in disseminating the learning; final serious case review reports will be published and findings from all other reviews, practitioner forums and audits will be summarised in LSCB annual reports.

Responsibility for undertaking a Serious Case Review

Regulation 5 (1)(e) and (2) of the Local Safeguarding Children Boards Regulations 2006 sets out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

"Seriously harmed" in the context described below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

• a potentially life-threatening injury;
• serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

In addition, even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

Role of the LSCB Critical Incident Evidence Committee (CIEC)

The LSCB Critical Incident Evidence Committee (CIEC), comprising of senior managers from partner agencies, has responsibility for considering cases referred to them. Primary responsibility of the group is to rigorously review agencies' contact and interventions with a child and family and consider as to whether a case satisfies the statutory criteria for initiation of a serious case review.

The CIEC meets on a monthly basis to review cases referred to them for consideration. A request to agencies for further information will have been made by the LSCB Administrator in advance of this meeting.

Following consideration of information from each of the partnership agencies, or their representative, the Chair of the CIEC advises the independent Chair of LSCB, as to the group's recommendations; to initiate a Serious Case Review (SCR); to initiate another review (see page 9), or undertake specific multi / single agency-actions. **The final decision to initiate a SCR rests with the independent chair of LSCB.**

The Independent Chair of LSCB confirms, in writing, his/ her decision as to whether a serious case, or other review, should be initiated. Immediately following the decision being made LSCB notifies Ofsted as to the decision of the independent chair.

Decisions on whether to initiate a serious case review will be made within one month of the LSCB being notified of the incident triggering the threshold.

Who Can Refer a Case to the LSCB Critical Incident Evidence Committee (CIEC)?

Any professional can refer a case for review to the LSCB Critical Incident Group. If, following review with their agency safeguarding lead or LSCB CIEC representative, a professional considers that a case requires consideration by the LSCB CIEC, the agency safeguarding lead should refer a summary of the case using the 'LSCB Process: Responding to Cases that May Warrant the Undertaking of a Serious Case Review' (CIGCON1) (Page 21) to the LSCB administrator Jacqui Taylor: Jacqueline.Taylor2@liverpool.gov.uk

The LSCB notifies the Independent Chair of SCB, LSCB Business Manager and Chair of the Critical Incident Group.

Reviews Other than Serious Case Reviews

Where cases do not meet the criteria for initiation of a Serious Case Review, the Critical Incident Group will consider whether an alternative review is required.

Different types of review considered by Liverpool LSCB include:

- Review of a child protection incident which falls below the threshold for an SCR; and
- Review or audit of practice in one or more agencies.

Further information about Multi Agency procedures for Serious Case reviews can be found: http://liverpoolscb.proceduresonline.com/chapters/p_serious_case_review.html

Serious Case Review – Publication

Working Together 2015 (p79) requires that 'All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.'

Final LSCB commissioned SCRs are published alongside the LSCB's response to the review findings in order to achieve transparency. The impact of SCR's, other reviews and wider LSCB Learning and Improvement activity in relation to improving services to children and young people and on reducing the incidence of deaths or serious harm to children will be described in the LSCB Annual report.

Role of the Merseyside Child Death Overview Panel (CDOP)

Local Safeguarding Children Board is responsible for ensuring that a review of each death, of a child normally resident in the LSCB's area, is undertaken by a Child Death Overview Panel.

Merseyside Child Death Overview Panel (CDOP) involves all five Merseyside LSCBs; Knowsley, Liverpool, St. Helens, Sefton and Wirral. Merseyside CDOP analyses any deaths occurring in children, aged from new born up to eighteen years old, and identifies any modifiable factors that could highlight areas for future improvement. Merseyside CDOP is responsible for reviewing deaths from the larger population across Merseyside in order to ensure it is better able to identify significant recurrent contributory factors.

Merseyside CDOP a core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. Merseyside CDOP also includes a professional from public health as well as child health.

In reviewing the death of each child, the CDOP will consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

Merseyside CDOP is responsible for:

a) collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death. *(Working Together 2015:81)*

Reviews and Audit Activity

Liverpool SCB are committed to regularly conducting a range of reviews, not only on cases which meet statutory criteria (*Working Together 2015:75*), but also on other cases which can provide useful insights into the way organisations are working together to safeguard, promote and protect the welfare of children.

Role of the LSCB Quality and Audit Evidence Committee

The Quality and Audit Evidence Committee of Liverpool LSCB ensures that there is a focus on thematic audits alongside multi-agency case file audits. Thematic audits are completed on issues as identified as the LSCB business priority areas.

The multi-agency audit process enables identification of areas of practice that are working well and those that need improvement across the partnership. Learning from the audits will be widely shared. Audits also promote service development through the identification of key practice issues which are addressed in action plans that are implemented and monitored by the LSCB.

Members of Liverpool LSCB are expected to feedback the outcomes and implications of the audit findings within their own agency, ensure that progress is made on any actions which they are responsible for and provide updates to the LSCB.

The process of multi-agency audit enables the LSCB to carry out its function of monitoring the effectiveness of what is done to protect children and monitor their welfare. Audits promote service improvement through the identification of key practice issues so that recommendations can be drawn together and action plans implemented and monitored.

Findings, recommendations and outcomes resulting from multi-agency audit feed into LSCB policy and practice guidance, LSCB training and development activity and strategy and commissioning processes.

Additional Learning and Improvement Activities

Any additional Learning and Improvement activity will be informed from a range of other sources including learning from other significant national inquiries and reviews, from national and local research findings and from listening to the voice of local front line practitioners, from children, young people and their families.

The LSCB will also include request from organisations / staff / managers details of cases where Multi Agency working produced improved or good outcomes.

Table 1 (page 9) details the range learning methodologies utilised by Liverpool LSCB.

Table 1 Learning and Improvement Framework - Activities

Type of Review/Audit	Responsibility / Initiation	Methodology
Serious Case Review SCR (statutory) (Case considered by Critical Incident Evidence Committee (CIEC) and LSCB Chair to meet SCR criteria)	LSCB Independent Chair Critical Incident Evidence Committee (CIEC) LSCB	Systems Methodology Independent Reviewer Review Panel Practitioners Group
Child Death Review (Statutory review of all child deaths). Any cases which identify concerns about multi agency working must be referred to CIEC for consideration of an SCR.	Merseyside Child Death Overview Panel (CDOP)	PAN Merseyside CDOP
Critical Case Review CCR (Review of a case which falls below threshold for SCR but where Learning can be elicited to inform future practice)	LSCB Critical Incident Evidence Committee (CIEC) LSCB Quality and Audit Evidence Committee LSCB Independent Chair LSCB Executive Group LSCB	Methodology Relevant to Case: Systems Methodology / Peer Review / Case Learning Session
Multi-Agency Thematic Review (Multi-Agency Review to establish why good and poor practice occurs to identify strengths and weaknesses in multi-disciplinary systems)	LSCB Critical Incident Evidence Committee (CIEC) LSCB Quality and Audit Evidence Committee LSCB Independent Chair LSCB Executive Group LSCB	Methodology Relevant to Case: Systems Methodology / Peer Review / Case Learning Session
Single Agency Thematic Review (Individual service review of practice in response to request from CIEC, LSCB Executive Group)	Critical Incident Evidence Committee (CIEC) LSCB Executive Group Service Lead	Management Review (Independent reviewer as required)
Section 11 Audit (Self-Assessment Audit to assess whether partners are fulfilling their statutory obligations under Section 11 of the Children Act 2004)	LSCB Chair LSCB Business Manager Service Lead	Annual multi-agency audit LSCB Panel scrutiny and challenge session
Multi Agency Audit (Review of the effectiveness of safeguarding activity within and across partner agencies through means of multi-agency audit)	LSCB Quality and Audit Evidence Committee Service Lead	Themed Audit linked to LSCB Business Plan 2014/16: CSE / Neglect / Early Help / CAMHS / Thresholds Audit Tools Interviews
Single Agency Audit (Review of effectiveness of safeguarding activity within an agency through means of single agency audit)	Critical Incident Evidence Committee (CIEC) Service Lead	Audit relevant to concern; Case File, Practice Review
Performance Management (Activity in response to analysis of LSCB Performance Information and Data)	LSCB Executive Group	Analysis of Performance Data
Other (Children / Families / Staff) (Activity in response to engagement with Children, Families and staff)	LSCB Executive Group	Voice of the Child Evidence Committee Family and Child evaluation of service Practitioner forums

Other Sources of Learning

Liverpool LSCB elicits learning from a range of sources as outlined below. This includes local findings from the work undertaken by the various LSCB Committees but also utilises information and Learning from National findings.

- National and Regional Reviews
- Audit: Multi Agency & Single Agency
- LSCB Performance Management
- LSCB Committees
- Other (Children / Families / Staff)

Role of the LSCB Committees in the Dissemination of Learning

This framework will apply to Liverpool LSCB and all partner agencies in their delivery of workforce development activities. It should also inform single agency frameworks to ensure connectivity and compatibility. It is also therefore essential that the members of LSCB Professional Development Committee reflect the wide range of both statutory and non-statutory bodies, partner organisations and other key agencies within the Adults, Children and Families workforce.

Membership is made up of those multi - agency professionals who act as key leads for Workforce Development within their agency or who have a role in supporting learning and improvement within their agency. It may also be appropriate to co-opt further members onto this group as appropriate for short fixed periods of time to complete actions required to disseminate local learning following a specific review.

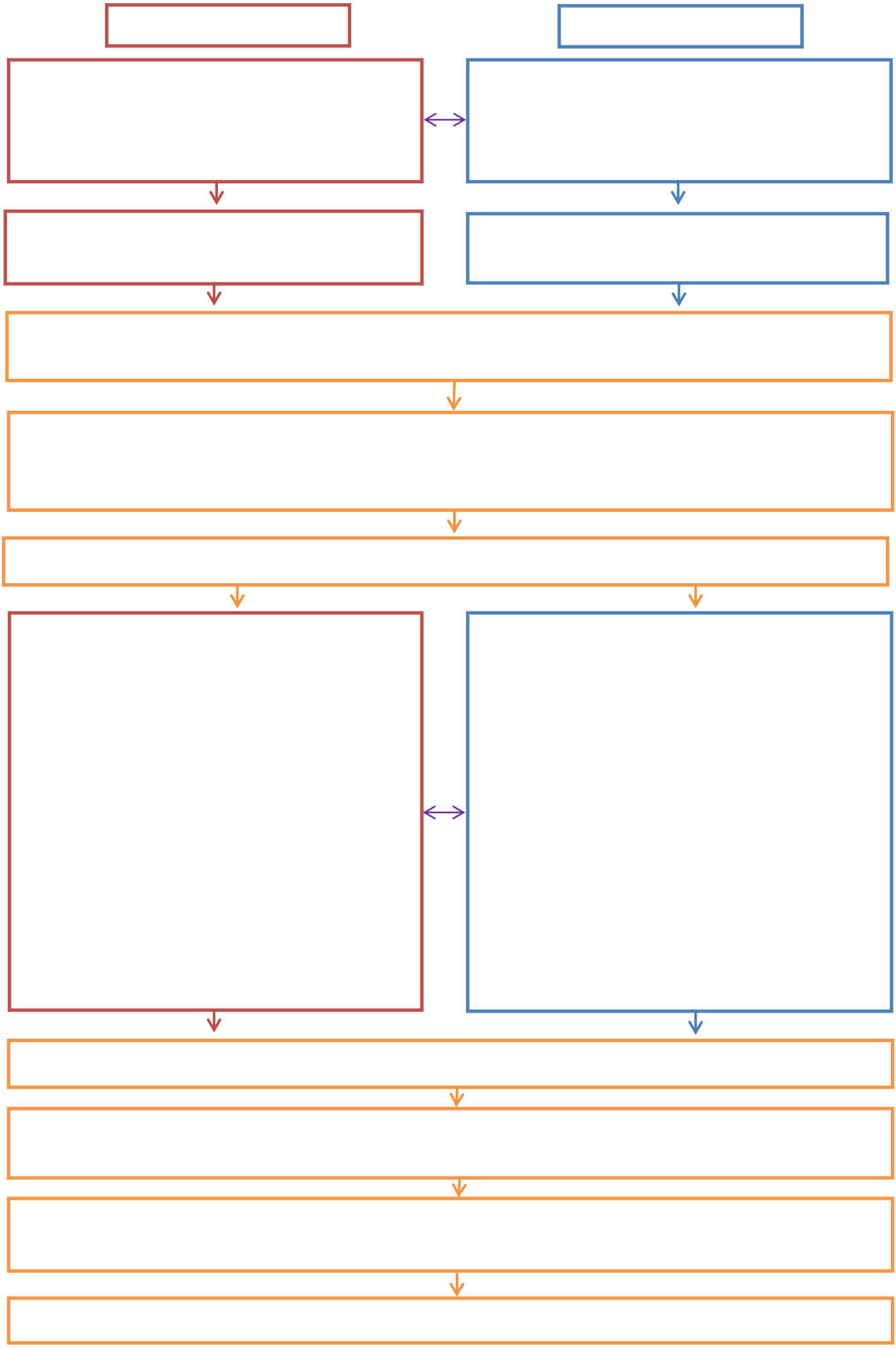
The learning and recommendations identified following review can be implemented in a number of ways, such as improved procedures and policies, supported through training programmes and in other relevant learning activities. In some cases it will be incumbent on individual agencies to consider how these recommendations can best be implemented and in turn provide assurance to the LSCB that this has been achieved effectively.

Members of the Critical Incident Group will be accountable for ensuring that actions for their agency have been completed and for ensuring that identified learning has been effectively disseminated within their agency. This will be completed in conjunction with the LSCB Professional Development Committee.

Completed action plans will be reviewed and the impact measures collated at the scheduled biannual meetings.

Key messages identified at review will also be integrated within LSCB Multi Agency Level 1 and Level 2 Training. Further training needs may also be identified.

LSCB Review - Learning and Improvement - Process Flowchart



Appendix One - Learning and Improvement Index

Learning from Audit

Type of Review:	Audit	Name: LSCB Application of LSCB Levels of Need at the Front Door
Date: Report to LSCB NOVEMBER 2016		

Case Overview / Methodology:

- Randomly selected 50 cases- 10 cases from each of our highest referring agencies (Police, Schools/Education Services, Health, NSPCC and Probation). All cases were referred in to us between December 2015 and February 2016
- Requesting the referring agency complete an audit tool about their referral. This audit tool related to how the referral was made, was the levels of need framework used, was an EHAT considered, was consent obtained and garnered the referrers view on why they referred the case when they did.
- Producing a referral tool for Careline to complete on the front doors perspective of the quality, appropriateness and timeliness of the referral (this was completed on 25 of the randomly selected cases)
- Selecting 10 of these cases to be audited by a multi-agency audit group with representation from Health, Schools, Police, LSCB, Careline, Social Care and Probation.
- In order to address an age balance that had randomly lent towards children age between 14-17, we picked a further 6 cases to audit of children aged under 12
- The multi-agency room met as a group with access to the previously completed audit tools from the referring agency and Careline, a copy of the referral record relating to the child and access to Liquid Logic to be able to further explore any issues that the review of the cases raised. Using this information they reviewed the 16 cases against an audit tool and noted recommendations against each case

Summary of Findings / Learning:

Main findings from 32 audit tools completed by the referring agencies:

- 19 **(60%) did NOT use the LSCB Responding to Need Guidance and Levels of Need Framework** while 13 (40%) did. Of the 19 referrals who did not use the guidance the agencies concerned were NSPCC, Health and Police
- 10 (31%) of them were either made or followed up with a VPRF1 (8 Police referrals) or a MARF (2 schools). The other **22 (69%) were not followed up with any written details after the initial referral was made.**
- 10 **(31%) of them were discussed with the referrers line manager while 16 (50%) were not** and 6 (19%) reported the question was N/A as they had no line manager
- **29 (91%) indicated that they had not considered an EHAT prior to the referral** while 3 had (1 from a school, 1 from Alder Hey and 1 form the police)
- **15 (47%) obtained consent prior to making the referral 17 (53%) had not**
- **10 (31%) ended up as a single assessment**, 7 (22%) were referred to another agency, 3 were given information and advice, 5 were NFA and in 7 cases (22%) the referrer did not know the outcome of the case.

- **Of the 25 referrers who knew the outcome of the referral 100% said that they believed the outcome of the referral was appropriate**

Quality and timeliness of the referral:

- Of the 16 cases audited: sufficient information was largely supplied to Careline.
- Timeframes for making referrals were appropriate and where there had been any delays in getting information to Careline, it was indicated that an internal single agency BRAG process had occurred and the risks around any delay had been managed.
- Wherever appropriate consent was obtained, however where consent was not obtained the referring agency was clear on why it had not been obtained and had always either attempted to contact the relevant person/people or it was a situation where obtaining consent was not appropriate.

Are thresholds to access assessment and services clearly and consistently applied was the level of need indicated appropriate, is it apparent that the responding to need guidance has been used:

- Referrals were by and largely pitched appropriately.
- There were some indications that the levels of need framework had not been used nor an EHAT considered, however even in these cases, the cases had been referred appropriately.
- There was an indication from one member of staff at one referring agency (probation) that at the time of making the referral that they had no heard of the Levels of Need framework or an EHAT, however the referral they made was still appropriate.
- EHAT's were routinely considered and where there were not used this was because it was either not appropriate (such as level 4 concerns around CSE), or in some cases, an EHAT was already open and referring this case to be stepped up was the correct course of action.
- NSPCC who don't use the MARF, make a number of referrals using their own single agency form. These referrals are made against a national framework and don't consider a local level of need nor consider local protocols such as EHAT.

Was the referral responded to in a timely and appropriate manner, what was the outcome of the referral and was this the correct response? Where the timeframes between the referral being made and response sufficient?

- Responses to the referral were wholly appropriate in relation to the information that was provided. Whether the referral was taken by Careline or the out of hours service the response was appropriate and dealt with in a timely fashion.
- There were no unnecessary delays when a referral was received and when there were occasions where by there were gaps in information from a referring agency, the agency was called back and gaps were chased up.
- When required extensive checks were made and all cases were stepped down appropriately or appropriately NFA'd or progressed to single assessment.

Findings

1. It was noted that while there were a number of referrals linked to domestic violence and school aged children, there was no evidence at the front door around whether schools had been notified (as per operation encompass).
2. It was referenced to the group that in cases where there was a significant delay between a police incident occurring and a police referral being made to Careline a BRAG rating exercise had taken place by the police to ensure that priority cases were dealt with in a timely fashion.
3. It became apparent in cases from health that from their perspective when completing the audit tool that they believed that very little work had been done by the individual referrer. When the referral record that children social care was reviewed it became apparent in these cases that extensive research and checks actually had been done by the worker involved and they had shared a very informative story with context and history to Careline.

4. The NSPCC responded several times saying “The MARF is not appropriate for NSPCC Helpline use”.
5. There was an indication that at the time of making the referral at least one worker from an agency (probation) had not heard of either the Responding to Need Guidance/ Levels of Need Framework or was aware of what an EHAT was.
6. In numerous referrals, be it over the phone, e-mail, fax, VPRF1, ethnicity was not provided on the referral. It is crucial that all known elements of demographics are shared when making a referral and referrers check their own single agency records to ensure they are transferring all requested information to Careline.
7. Several referring agencies commented that no feedback was provided to them on the outcome of the referral, even in cases where Careline had indicated in their records that they had e-mailed the agency to update them on a case.
It was suggested at the audit group that in other LAs each agency has a set agency e-mail address where feedback can be shared of referrals and some LA’s now have a process whereby an e-mail is automatically sent to a referrer when a case is picked up by a worker in Liquid Logic.
8. Sometimes when a referral was made, a single incident that triggered the referral was treated in complete isolation by the referring agency even when the agency had a significant case history on their own internal records. In these cases if Careline called the agency back and requested further details they were provided with the information without any problems, however it would have been beneficial to receive this information in the first place.

Improvement Activity:
LSCB Quality & Audit Evidence Committee (QAEC) to develop response and actions in response to Audit and findings. Refer to LSCB Team for Update

Type of Review:	**Audit**	**Name: LSCB Neglect Audit**
Date: Report to LSCB September 2015		

Case Overview / Methodology:
The audit process comprised of two distinct sections, the first being a case file audit of the written records held on the child. The case file audit tool was distributed to the lead auditors for each agency as represented at the audit sub-group of the LSCB. The lead auditors then determined who would complete the audit within their agency. There was substantial variation in who completed the audit tool from the frontline practitioner, line manager to the lead auditor who had had no direct involvement with the case.
It was agreed that the multi-agency case file audit would review 10 cases as a representative sample. It was agreed that the cases would be picked from across the continuum of need to demonstrate how neglect is assessed and managed across services.

Summary of Findings / Learning:
1. There was limited engagement with the full audit process from a number of agencies. The reduced involvement in the process limits the findings of the audit.

2. It was reported that the progress of some cases had been hindered due to a change in professionals working on the case. It was reported that new workers on the case often did not have time to read the full chronology of the case prior to commencing work with the family. The failure to review the chronology resulted in some workers not understanding the historical details of the family.

3. Agencies that have made referrals to Children’s Social Care are not always informed of the outcome of the referral. The joint duty of Children’s Social Care to inform agencies of the outcome of the referral and agencies making referrals to pursue the outcome of the referral should be stated.

4. The practitioner focus group question used to elicit the aims of the practitioner in terms of outcomes for the child was consistently poorly answered. The audit sub-group will review this question to see if there can be any alterations made to make it more understandable to practitioners. This will be reviewed

within the next thematic audit as there is a potential that this could reflect a wider issue of multi-agency work not being child outcome focused.

5.In some of the cases practitioners identified that there had not been timely intervention with families this appeared to be more easily identified when the child had moved in from a different local authority area. There was some criticism made of decisions that had been made in Liverpool and as such there needs to be use of an appropriate assessment tool for neglect. The majority of the agencies reported that they were not using an specific assessment tool for neglect and would welcome the introduction of such a tool.

6. In two cases it was identified that when parents were serving custodial sentences they became removed from the safeguarding plans and work that was being conducted with families. It was identified however that despite parents serving custodial sentences they still had a direct impact on the family either through the children visiting parents or through the emotional impact of the separation or risks to the family on the parents release. It was noted that it appeared that there had been limited involvement with the prison service to inform the plans for the family and this should be considered in future cases.

7. Practitioners appeared to have the greatest difficulty in understanding the distinction between when an EHAT and when a Child In Need Plan was required. Training on the thresholds of need should focus on this area to give practitioners a more in depth understanding.

8.There was evidence of good information sharing systems between Children's social care and AHCH and primary care when a child was subject to a child protection plan however communication was limited when the child was either de-planned, looked after or subject to a child in need plan.

Improvement Activity:
Audit Referred to LSCB Professional Development Committee (Single agency actions implemented and reporting to L & I Group)

Type of Review:	**Audit**	**Name: LSCB Child Sexual Exploitation (CSE) Audit**
Date: Report to LSCB June 2015		

Case Overview / Methodology:
Initially the audit tool was devised following a review of the Rotherham CSE report and the Pan-Merseyside CSE Strategy with the aim of benchmarking current practice against the risks that were identified in Rotherham and the required practice in Merseyside. The initial CSE audit tool was developed by the Audit Sub-Group in consultation with the CSE Co-Ordinator.

Over 2013/14 93 cases were discussed at Liverpool MACSE meetings therefore it was agreed that the multi-agency case file audit would review 10 cases as a representative sample. The full lists of the names of the cases were supplied by the CSE coordinator and 10 names were then selected. The cases were selected to ensure that there was a geographical spread across the city to explore if there were any differences within service provision according to the area that the child or young person lived in. The cases selected included both male and female victims of CSE to assess if there were any gender differentials in service provision. The cases were further selected to ensure that there was representation of victims across the age range. The ethnicity profile of the victims was examined and a case was selected to ensure that the experience of children and young people from ethnic minorities were represented. The educational establishment that the child or young person attended was taken into account when selecting cases to establish if there are any hotspots of concern. The cases were further selected to ensure that there was a spread to reflect cases where the victim has not been assessed as being at high risk of CSE. Subsequently however, the audit group agreed to focus on cases that had been heard at MACSE on more than one occasion. The focus on these cases was due to the fact that these were determined to be the most vulnerable and potentially held a window to the systems and processes of MACSE. The case list was therefore reduced to 9 children in total.

Summary of Findings / Learning:

1. CSE 2 form (risk assessment tool) does not appear to be distributed to all of the agencies involved with the young person as there was limited reference to this tool in any of the agencies records.
2. There was discussion regarding whether the scoring of the risk assessment tool gives partner agencies sufficient information if they have not been part of the MACSE meetings. Instead of scoring should the information that is transferred be in relation to areas of risk and accompanying plans/ actions that the agency can undertake with agencies / young people.
3. The group discussed whether there should be some form of accelerated protocol for children and young people who are at risk of CSE to get into alternative school provision – the issue seemed to be that children and young people who were at risk of CSE needed to be occupied / distracted from the risks that were around them. A lot of the provision that was offered was for a limited time period – eg 2 days a week yet there seemed to be evidence of children and young people having better outcomes if they were involved in full time provision.
4. LSCB need to issue guidance / directive on when and how to flag records. Procedures should also be updated to include a clear CSE pathway which lists within it services that are available for children and young people.
5. It is felt that there are numerous limitations in terms of the audit process that was used. The disruption to the audit process in respect of the changing cohort of cases to be audited cannot be overstated, this impacted on the timescales for the completion of the audit and for the report and findings to be discussed at the LSCB within the original specified deadlines.

Improvement Activity:

Audit referred to LSB CSE Sub Group

Type of Review:	**Ofsted**	**Name: Thematic Inspection - In the Child's Time: Professional Responses to Neglect**

Date: March 2014

Case Overview / Methodology:

Summary of Findings / Learning:

- Neglectful families are complex, confusing and sometimes overwhelming for practitioners;
- Some assessments focused almost exclusively on the parents' needs rather than analysing the impact of adult behaviours on children;
- The pervasive and long-term cumulative impact of neglect on the well-being of children of all ages is also well documented;
- All aspects of children's development can be, and are, adversely affected by neglect, including physical and cognitive development, emotional and social well-being and children's mental health and behaviour;
- The need to take decisive and timely action to protect children is supported by a wide range of research;
- Nearly half of assessments did not take sufficient account of the family history, or did not convey the impact of neglect on the child;
- Non-compliance and disguised compliance by parents were common features in cases reviewed;
- In some cases children became lost in the assessment in the same way in which they are lost within their own families;
- Drift was identified at some stage in the child's journey in a third of all long-term cases examined;
- Routine performance monitoring and reporting arrangements to LSCBs infrequently profile neglect.

Improvement Activity:

Liverpool Neglect Strategy
LSCB Multi-Agency Neglect Learning & improvement Session developed and deliverd (See LSCB Multi Agency Learning & Improvement

opportunities calendar) Neglect as LSCB Priority 2014-2016 Relevant Single Agency Learning Activities

Learning from Reviews (including Serious Case Reviews)

Type of Review:		**Name:**
Date:		
Case Overview / Methodology:		
Summary of Findings / Learning:		
Improvement Activity:		

Type of Review:	**Serious Case Review**	**Name: Child A (Alex)**
Date: Report Completed July 2016		
Case Overview / Methodology: A Serious Case review was undertaken in 2016. Details of the case including a case overview cannot be shared at this time due to ongoing investigations.		
Summary of Findings / Learning: 1. The guidance in relation to bruising in non-mobile babies is unequivocal and states that any bruising in non-mobile babies is a potential indicator of risk and that a safeguarding referral must be made where it is present. 2. Professionals should always check out parental understanding and give additional support where necessary. Where assessments about parenting are being undertaken (either formally of informally), ensure that parental understanding of developmental milestones is discussed and that any observations about parenting capacity are recorded and included in an assessment which is shared amongst relevant professionals. 3. Where there is limited multi-agency input into the final CIN meeting; there may be a lack of rigour in ensuring that families are supported sufficiently during transition to Early Help services. If the case is being 'stepped down to early help' ensure that the relevant professionals who will be offering continued or ongoing supported are invited. 4. If there is little focus on exploring father's potential vulnerabilities it is possible that subsequently risk factors may not be identified. Professionals should therefore always take full account of the influence that fathers have on the family and ensure that any vulnerabilities or risk factors feature in		

assessments, referrals and interventions.

Improvement Activity:

- Learning incorporated into LSCB multi-agency Learning from Review Sessions and case study used at two day Working together Training (Induction). (See LSCB Multi Agency Learning & Improvement opportunities calendar).
- Multi Agency Practice Guidance 'Responding to concerns about bruising in Babies and Children not yet independently mobile' has been developed.
- Sixty Briefing undertaken to multi agency workforce co facilitated by colleagues Alder Hey Rainbow Centre.
- SCR Newsletter Features, Findings and Learning developed and widely disseminated.
- SCR newsletter uploaded to LSCB website and Early Help Directory.
- Review activity captured across single agency workforce through LSCB Professional Development Committee.

Type of Review:	**Serious Case Review**	**Name: Child C (Chris)**
Date: Report Completed July 2016		

Case Overview / Methodology:

A Serious Case review was undertaken in 2016. Details of the case including a case overview cannot be shared at this time due to ongoing investigations.

Summary of Findings / Learning:

1. The grading of domestic abuse incidents is determined by local policy guidelines which are based on the judgment of those attending the incident or those subsequently subject to disclosure about the incident. When a MERIT risk assessment has not been completed or refused the reasons for this should be noted. All agencies should ensure that in cases where victims who do not have English as a first language, this should not act as a barrier to completion of the MERIT risk assessment.

2. Professionals within agencies should be clear about information sharing requirements in relation to domestic abuse incidents and made aware of the importance of the use of interpreters and the impact this may have on disclosure and the pathway to specialist domestic abuse services for migrant and other victims who speak little or no English?

3. Current practice within agencies, in relation to cultural competence and safeguarding should be in line with national professional guidance and responsive to the needs of specific communities. Agencies must ensure that professional interpreter services are always used by agencies; the use of family members or others is not acceptable practice.

4. The availability of health and social care records for migrants to the UK has been identified as a significant national issue. As a result, services are

reliant on self-report information upon which to base professional judgments and the provision of services.

Improvement Activity:

- Learning incorporated into LSCB multi-agency Learning from Review Sessions and case study used at two day Working Together Training (Induction). (See LSCB Multi Agency Learning & Improvement opportunities calendar).
- Multi Agency Learning Event 'Safeguarding Children in New and Emerging Communities' taking place 1st February 2017.
- SCR Newsletter Features, Findings and Learning developed and widely disseminated.
- SCR newsletter uploaded to LSCB website and Early Help Directory.
- Review activity captured across single agency workforce through LSCB Professional Development Committee.

Type of Review:	**Multi Agency Thematic Review**	**Name: Family M**
Date: Report Completed July 2016		

Case Overview / Methodology:

This Multi-Agency Thematic Review concerns the four M children, of whom the younger three were, from birth, subject to long standing parental neglect; and later on, sexual abuse and exploitation, exposure to drug and alcohol misuse and criminal activity, non-school attendance, domestic abuse, poor home conditions and concerns about hygiene, injuries to the children, mental health issues and self-harming incidents.

There had been ongoing multi-agency involvement with the family since March 1996 and concerns had been raised that multi-agency interventions were ineffective and had failed to safeguard the needs of the M children.

The case was considered by the Liverpool Safeguarding Children Board in early 2015 for a Serious Case Review and deemed not to have met the criteria in Chapter 4 of 'Working Together' 2015. However, it was the view of the Chair of the Board that an independent Multi-Agency Thematic Review should be commissioned in order to address any criticisms and identify any lessons.

Summary of Findings / Learning:

Child Sexual Abuse and Sexual Exploitation

- Practitioners would benefit from clarity from LSCB with the regards to the development of a practitioner 'end to end' flow chart of the journey of the young person through the CSE pathway.

- A lack of clarity in relation to the current protocol in regard to the Child Sexual Exploitation pathway and procedures
- A lack of a coordinated Child Protection/CSE Plan
- Deficits in the quality of agency management oversight and supervision of practitioners

The Effectiveness of Multi-agency Practice and Action Regarding the Children's neglect.

- Placement plans with extended families as part of either a Child Protection Plan or CiN plan need to be followed through to completion by CSC and core/CiN groups.
- CiN plans when 'stepped down' from Child Protection Plans need to be subject to a robust and rigorous APIR (assessment, planning, implementation, review) case management cycle approach that includes effective management oversight.
- Single assessments need to be updated when proposals are made to return children who are, or have been subject to Child Protection Plans, to carers who have caused them significant harm.
- Subject to an updated single assessment, consideration should be given to putting children on repeat Child Protection Plans where they have previously been placed with extended family or friends and de-planned; and there are proposals to return them to carer's who have caused the original significant harm.
- Core/CiN groups should, when necessary, challenge the efficacy of premature case closure by an agency and use the LSCB dispute resolution process when needed.

Episodes of Care Planning

- The previous case history should always be factored in to the current assessment of need and risk for children.
- The dangers of the ' Start again syndrome ' need to be considered as do the impact and consequences of 'cumulative harm' for the child, especially in long standing and complex cases of neglect.
- The child or young person's voice and sense of their ' lived experience' should be central to the case management cycle of assessment, planning, implementation and review (APIR)
- Each child should have their own assessment, especially where there is long standing neglect.
- Plans should have SMART objectives and outcomes for the child/young person.
- Case drift should be avoided through reflective management supervision, timely decision making, effective review and challenge by the Independent Reviewing service and the recourse to legal pre-proceedings when necessary.
- Evidence of an effective core group progressing the Child Protection Plan and meeting regularly.

Improvement Activity:

- The efficacy of the current CSE Protocol and Strategy is currently being reviewed. Once a new protocol has been developed, a programme of quality ('Deep dive') case audits into multi-agency practice will be undertaken in order to test the efficacy of any changes. *Ongoing*
- Further development and monitoring of the action plan completed following (July 2016) Ofsted, 'Child Sexual Exploitation and missing from home, care or education' Joint Area Targeted Inspection.
- The LSCB has given clarity and developed a practitioner 'end to end' flow chart of the journey of the young person through the CSE pathway.

Type of Review:	**Serious Case Review (Lancashire SCB* supported by LSCB agencies)**	**Name: Child N**
Date: Report Published May 2015		

Case Overview / Methodology:

In May 2014 Child N and his mother died in a house fire in Liverpool. At the subsequent inquests, the coroner ruled that Child N had been unlawfully killed and that his mother had deliberately started the fire. The family had extensive involvement with professionals in both Lancashire and Liverpool with longstanding on-going private law proceedings.

The Serious Case Review concluded that the professionals involved with Child N and his family, in both Liverpool and Lancashire, could not have predicted or prevented Child N's death. However, the review has identified areas of learning for practitioners and organisations that may help you in working with families in the future.

Summary of Findings / Learning:

1. Child N's mother had four mental health assessments between 2004 and 2012 and none resulted in a diagnosis of mental illness. However, she did have symptoms of anxiety and her behaviour was at times odd and concerning. Whilst the coroner and the review both concluded that nobody could have predicted mother would tragically kill Child N or that he was at immediate risk, there had been opportunities for people to really understand what it was like to be her child; to be living with her anxiety, unreliability and behaviour.
2. The mother of child N made numerous allegations that father had been violent towards her, or threatened her with violence; directly or through associates. There were no witnesses to these incidents, although professionals took them seriously. At a Finding of Fact Hearing in 2010, most of the allegations against father were found unproven. The small number that were deemed to be true were not felt to have been as serious as mother alleged. However, professionals involved with the family were not told of this outcome, and continued to be unsure about who or what to believe amidst continuing allegations.
3. Child N was the subject of repeated private and public law proceedings for three years of a five year life. There was ongoing hostility between parents, and mother tested and defied Court imposed decisions. Child N was known by different names to each parent, and the adults caring for him had differing routines and expectations.
4. This review raised a number of issues about workloads and practice. Some agencies had recording systems that made it difficult for practitioners. In some agencies workloads and vacancy rates impacted on the ability to deliver a high quality service.

Improvement Activity:

Learning incorporated into LSCB multi-agency Learning from Review Sessions (See LSCB Multi Agency Learning & Improvement opportunities calendar)
SCR Newsletter Child N widely disseminated

Type of Review: Serious Case Review	Name: LSCR 1402 (Child known as Mary)
Date: Findings to LSCB June 2014	
Case Overview: Unexpected death of a six month old baby. Death recorded as 'unascertained' and number of risk factors linked to sudden unexplained death in infancy (SUDI) present including parental smoking and prematurity. Family were not in receipt of any services at the time of Mary's death, previous concerns had been expressed about the care of the older children.	
Summary of Findings/Learning: 1. The cumulative impact of neglect can go unrecognised where the history and context of all available information is not considered. 2. There is confusion and tension between agencies and Careline where agencies consider thresholds for referral in relation to Neglect to be too high. 3. CAF is not well embedded into multi-agency practice and its status as a form of early intervention is not clear. 4. The failure to effectively assess whether parents have the capacity, willingness and motivation to work with professionals on agreed concerns results in increased frustration for all parties and leads to drift and delay in addressing the needs of children, especially where neglect is a factor. 5. The lack of a multi-agency system for monitoring missed medical appointments results in professionals missing potentially significant indicators of neglect. The use of the term 'Did Not Attend' is misleading. The implications of repeated 'no access' visits should be made explicit for staff in all agencies	
Improvement Activity: • Learning from review session with author 07.11.14 • Learning incorporated into LSCB multi-agency Learning from Review Sessions (See LSCB Multi Agency Learning & Improvement opportunities calendar) • SCR Newsletter Child Mary widely disseminated	

Type of Review: Serious Case Review	Name: LSCR 1402 (known as Child Maisie)
Date: Findings to LSCB June 2014	
Case Overview: Maisie died unexpectedly aged 25 days old. Cause of death as recorded as Sudden Infant Death syndrome. Two previous children in the family had also previously died of natural causes shortly after birth. Maisie's mother had a history of alcohol misuse and had previously received therapeutic interventions to reduce her consumption and develop coping mechanisms. There was a history of Domestic Violence in the parent's relationship.	
Summary of Findings/Learning: 1. There were a number of opportunities to engage the family in CAF that were not taken by professionals. Had CAF been considered there may have been an opportunity to engage mother and increase resilience. 2. Information about a previous Serious Case review relating to this family was not shared across local authority borders, nor was it shared across agencies. 3. Thresholds for intervention are perceived differently by professionals within the safeguarding system.	
Improvement Activity: • Authors presentation to LSCB June 2014 • Learning from review session with author 07.11.14 • Learning incorporated into multi-agency training	

- Learning incorporated into LSCB multi-agency Learning from Review Sessions (See LSCB Multi Agency Learning & Improvement opportunities calendar)
- SCR Newsletter Child Maisie widely disseminated

Type of Review: Critical Case Review	**Name: LCIR 1310 (Child known as John)**
Date: Findings to LSCB June 2014	
Death of a three year old child. No apparent suspicious circumstances associated with the death and John was subsequently found to have died from natural causes. There had been significant family history of involvement with Children's Services. At the time of John's death John and his siblings were the subjects of Child in Need Plans.	
1. Multi-Agency Professionals can work together harmoniously and create the pathway for families to engage and achieve better outcomes for children 2. Maintaining a focus on alleged perpetrators in initial safeguarding planning is critical to achieving a whole family approach to safety planning 3. Children's Plans and Reviews of Plans need to clear in objective, task and outcome focussed.	
Improvement Activity: • Authors presentation to LSCB June 2014 • Learning from review session with author 07.11.14 • Learning incorporated into multi-agency training • Learning incorporated into LSCB multi-agency Learning from Review Sessions (See LSCB Multi Agency Learning & Improvement opportunities calendar)	

Type of Review: Thematic Review	**Name: LTR 1402 M (Adult)**
Date: Findings to LSCB June 2014	
Case Overview: Murder of a 19 yr old YP A by a group of youths by stabbing. Following police investigations 6 young people (5 children) and one young man were charged with murder.	
Summary of Findings/Learning: 1. There is a lack of clarity about procedures and processes for intervention in cases where there is family/domestic violence initiated by young people under the age of 16 years. 2. The inter agency information sharing systems relating to youth gang activity are not sufficiently developed to allow early identification and multi-agency interventions by agencies. There are additional constraints because of "silo" working and the agency focus on specific individual cases. 3. There is a fundamental weakness, at present, in that the ranges of therapeutic interventions for young people with "conduct" type behaviour disorders are not producing positive outcomes. Other therapeutic models such as Multi-systemic Therapy should be explored. 4. There is a significant gap between strategic aspirations/procedural guidance and practice in relation to ending youth and gang violence. To be effective the planning processes need to address how policy is going to be implemented at a practitioner level. 5. There was very little evidence, from these cases, about the effectiveness of early intervention and parenting programmes, although most of the children displayed behaviour and attachment problems from an early age. It would be prudent to ensure that the effectiveness of Early Years interventions is closely	

monitored
Improvement Activity: • Authors presentation to LSCB June 2014 • Learning from review session with author 07.11.14 • Learning incorporated into multi-agency training • Learning incorporated into LSCB multi-agency Learning from Review Sessions (See LSCB Multi Agency Learning & Improvement opportunities calendar)

National: Published Case Reviews in the UK:

In collaboration with the Association of Independent LSCB Chairs, NSPCC store published case reviews in a National case review repository. The repository stores published case reviews from 2013 to date.
http://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/serious-case-reviews/

Learning from Merseyside CDOP

Review / Activity:	**Source: Merseyside CDOP**
Date / Period Covered: 2015/16	
Summary of Findings/ Learning: **Infant Mortality:** Infant mortality is an area of concern for the north-west and in particular Merseyside. Greater Manchester Public Health began planning a north-west workshop to be held in 2016. CDOPs were largely unrepresented although it was information from one of the Greater Manchester CDOP Chairs that instigated the interest and henceforth the planned work. The aim of the workshop is to share best practice with a view to substantially reducing the infant mortality rate. **Birth-weight:** Low birth weight, one of the known risk factors for infant deaths, was evident in 58 out of 113 categorised deaths. 20 of the 57 neonatal and 6 of 19 infant deaths had smoking within the household recorded as a factor. Mothers smoking is noted as a major risk factor contributing to low birth-weight. Babies born to women who smoke weigh, on average, 200g less than babies born to non-smokers. It is therefore imperative that we ensure the questions relating to social factors are completed as comprehensively as possible. There were 5 mothers aged 20 years and under and of these 5 the birth weight of 2 was fine, a further one was slightly under and 2, both premature, had low birth weights. In response to learning from neonatal and infant reviews and the risk factors inherent in unsafe sleeping practices a Safe Sleeping Campaign was launched in December 2015 and remains ongoing. **Body Mass Index:** Awareness that the mothers in a significant number of neonatal deaths have high body mass index (BMI) led to the question being added into the agency report form with a request that agencies date the figure regarding when it was calculated. This will assist CDOP to consider this over a greater period of time and identify whether this is a consistent feature in child deaths. The emerging issue has been discussed at the North West CDOP	

meeting and it will be proposed at the next meeting that all CDOPs involved gather this data to aid analysis.

Incidence of Statutory Orders/Child Protection Plans/Child in Need Plans: There were no deaths of children on child protection plans (CPP) but for one child death in Liverpool there had been a previous child protection plan. This is the same child who was looked after at the time of death and had a life limiting condition. The remaining four areas had no child deaths relating to looked after children.

With regard to child in need status (CiN) Sefton and St Helens had the most child deaths across Merseyside of children with this status. Liverpool and St Helens had the greater number of child deaths where a child in need status had previously applied. Knowsley and Wirral had the fewest deaths where child in need status previously applied.

Deprivation and child Deaths: The link between deprivation and a higher risk of child deaths is long-established and can be connected to a variety of factors including the generally higher prevalence of risk-taking behaviour, unhealthy lifestyles and poorer domestic situations leading to violence etc. Figures show that from the 115 deaths categorized in 2015-16, 52 deaths occurred in the two most deprived quintiles which accounts for 45% of the deaths, compared to 31 deaths in the two least deprived quintiles, which represents 27%. When Merseyside deaths are considered relative to the national picture it shows that 85, constituting 74% of child deaths, occurred in the two most deprived quintiles and only 13% featured in the two least deprived quintiles. Detailed information relating to causes can be viewed in the Merseyside CDOP Annual Report 2015-16 on the LSCB website.

Suicide: There have been 24 deaths from suicide since 2008 but seven occurred in Merseyside during 2015-16, the same as during 2014-15. There were six deaths categorised as suicide in 2015-16. Merseyside CDOP plan to focus on suicide prevention and will begin by establishing what is happening in areas at the current time.

Assessing parental risk factors at time of death: The need for greater reporting of social factors to assist in more detailed analysis has to be emphasised again this year as in previous years. It has been shown that it is important to have information relating to mothers, smoking and neonatal deaths but it is equally important to record whether other adults in the household smoke. Likewise, it is appropriate to know what family life experiences children have prior to their death to assist with engaging in informed scoring, categorisation and influencing any recommendations for change.

Improvement Activity:

CDOP Briefing sessions delivered
Safer sleeping sessions delivered 2015/16

Learning from Performance Management

Review / Activity:	Source: LSCB Priority Leads (Ref: LSCB annual Report 2015/16)
Date / Period Covered: 2015/16	

Summary

Priorities: Neglect

- Neglect is no longer the highest category for children on child protection plans. This is contrary to previous yearly trends. It is difficult to attribute this change to a single casual factor. Emotional harm is now the highest reported category. There is an overlap between emotional abuse and many forms of child maltreatment and this is especially true of neglect. The rate of children who were the subject to a protection plan (at the 31st March 2015) per 10,000 children is below the core city average. There was a slight reduction in 2015/16 from 2014/15, 47.4 compared to 49.9.

Priority 2: Early Help

The rate of children per 10,000 of the population (< 18 year) who have been the beneficiary of an early assessment in 2015-16 was 264.9 per 10,000. This equates to a 20% increase on the previous year. The North West average reported at the end of Quarter 2, (more recent information is not yet available), was 47 per 10,000. Based on this figure, Liverpool's performance is 10% higher than the Liverpool average.

This increase is a positive development however it continues to compare unfavourably with the Liverpool Children in Need population. The rate per 10,000 of children, who became Children in Need 2014/15 in Liverpool was 461.6 compared to the core city average 396.5 per 10,000. The Children in Need rate per 10,000 for 2015/16 in Liverpool is 454.7. It is not possible to compare this to the core city average as data is not yet available. (Figures will be reviewed when the 2015/16 national information is available.) The number of Children in Need is unlikely to reduce unless there is significant acceleration in the number of child beneficiaries of early help. This also applies to the number of children subject to a child protection plan and the number of Children Looked After.

The continued overall increase in the number of child beneficiaries is encouraging. Primary schools continue to make positive progress. There has been an increase of 70.4% (child beneficiaries of early help assessments) compared 2014/15. This positive development is also mirrored by secondary schools where there has been an increase of 60.5% on the previous year. It is important to note these relatively high percentages reflect the low levels of activity in the preceding year and whilst it is encouraging that the number of early help assessments in secondary schools continues to increase, the average number at year-end is just 4.48 per secondary school.

Four agencies continue to be responsible for 77% of the total number of assessments reported in 2015/16; Children's centres [30%]; Primary Schools [20.7%], Outreach Family Support Workers located in the three Early Help Hubs [12.7%], School Outreach Support Service [13.3%]. Despite improving performance management information it is still evident that early help is not yet fully embedded across the entire children's workforce and that agencies appear to be risk averse when expected to support families with early help services across multi-agency partnerships.

Children's centres accounted for 30% of all assessments in 2015/16. Future funding for centre staff is not yet secure and as such there is a risk this workforce could potentially shrink by two thirds. This would have a significant impact on early help activity.

It is very encouraging to note that, from performance information, in Quarter 4 there was an increase in the number of assessments opened by health

visiting and school nursing services. The numbers of assessment in the final quarter were equal to the total numbers within the preceding three quarters. It import this universal health service continue to work to try to embed early help. Despite the increase in the final quarter, health-visiting services accounted for only 3.4% of all early help assessments in 2015/16. Additional resources have been secured to support health-visiting services.

It is important that midwifery services also closely review their front line staff engagement with early help. Midwifery services account for only 0.1% of all early help assessments in 2015/16. This equates to just one early help assessment. Midwifery services should be using the early help assessment tool prior to contacting Care Line to refer women for a social care assessment when they are 26 weeks pregnant. Additional resources have been secured to support midwifery services.

There were 3515 referrals for the first 2 quarters in 2016/17, compared to the same period in 2015/16 (a reduction of 12.4% - 499 referrals less). However, the full year forecast is a reduction of 6.6% taking account of seasonal variations. This is in addition to a 5.4% reduction in 2014/15 and the 7.2% reduction in 2015/16. The casual factors are unlikely to be singular however, the reduction correlates with evidence of an increase early help activity. (Note: The development of a MASH is usually followed by an increase in referrals to children's social care. This is not evident in Liverpool).

There has been an increase in the number of referrals stepped down or closed with Care Line. These referrals do not meet the threshold for statutory intervention. This indicates that additional workforce development is required to embed a clearer understanding of the Levels of Need and to enable practitioner to manage perceived risk. Workforce develop initiatives are planned.

Priority 3: Child Sexual Exploitation

- Victims of CSE are predominantly female (92%). A significant and increasing number of victims are however male (8%).
- The ethnicity profile and distribution of victims broadly matches the ethnicity profile of the city.
- The greatest number of referrals to the MACSE relate to children aged 14 – 16.
- Approximately 20% of referrals to MACSE relate to children aged under 13.
- The distribution of CSE victims is citywide.
- The majority of CSE victim are White British
- Perpetrators or those suspected of perpetrating CSE are predominantly males however an increasing number of females are known or suspected of perpetrating CSE.
- There is no evidence to date of a link to any particular ethnic group or community.
- Internet and social media activity relate to a majority of CSE referrals. (Grooming in this context is a particular issue)
- The majority of referrals to MACSE come from Police and Children's Social Care.

- The profile information in relation to victims and perpetrators is derived from Multi-Agency CSE (MACSE) meetings via forms CSE1 and 2. These tools are currently being reviewed in order to capture additional information required.

- The impact of significant awareness raising activity and training for professionals is evidenced by an increasing number of referrals into the Liverpool MACSE during 2015/16.

Whilst an increase in referrals to the Liverpool MACSE is positive and indicates awareness of CSE indicators and behaviours on occasion, following appropriate investigation, it can be found that some referrals do not relate to CSE. Work is continuing that supports professionals to more accurately respond to concerns so that the response, support and intervention appropriately address the needs of all children and young people as they emerge or become known. As part of this work LSCB, in consultation with a range of partners, continues to update its Responding to Need Guidance and Levels of Need Framework.

At this time there is no information to specifically determine the type of CSE that children in Liverpool are experiencing as this information to date has not routinely been collected. Revision of referral documents in intended for 2015/16 which will enable a profile of CSE type; Boyfriend Model, Online, Organised/ networked sexual exploitation or trafficking, Party Model, Peer to Peer, Group / Gang exploitation, to be better determined. Further work is also required to better understand the outcomes of cases referred to MACSE. A review and revision of documentation to include a MACSE plan for each case referred is currently being progressed.

Priority 4: Child & Adolescent Mental Health

LSCB chose Child Mental and Emotional Health (including that at CAMHS Tier 2/3) Self-Harm and Attempted Suicide recognising that Liverpool has had a number of serious incidents related to young people some of whom were in receipt of mental health services in the last 5-6 years, some of which were subject to a Serious Case Review (SCR). In addition, the challenges that some families are experiencing means that children are living in circumstances which do not support the development of resilience to promote good mental health. This means that commissioners and providers of services to children and families have to ensure that services are able to support families to do this in the broadest sense, and that across Liverpool the different strands of work that contribute to this are brought together to ensure maximum impact. The LSCB having a focus on this important area of work emphasises the importance of this work.

Priority 5: Children Affected by Criminality

- The number of offences committed by children and young people in Liverpool decreased by 18.4% in 15/16 when compared with 14/15.
- The number of First Time Entrants to the Criminal Justice system has been declining since 2010 and continues to decline.
- In 2015/16 there were 124 new referrals to the Prevention team in Targeted Services for Young People, only one of these young people went on to offend.
- Of the young people who participate in the Out of Court Disposals project between Merseyside Police and Targeted Services for Young People 90% have not offended in the 12 months following the intervention.
- The under 18 female who offend in Liverpool is 7% compared with the national average of 18%.
- The number of custodial sentences imposed fell from 154 sentences in 2014/15 to 103 in 15/16 and the number of young people receiving custodial sentences fell from 47 in 14/15 to 32 In 15/16.
- The number of offences committed by young people, at high risk of re-offending this has fallen by 54% between April 2014 and March 2016.

Priority 6: Front Door

Volume of demand on Careline: Liverpool has a very high referral rate to the front door. Liverpool has the third highest referral rate in the north west of England and continues to be a statistical outlier. The demand on Careline is far higher than the published referral rate by the DfE. There are a large number of contacts that require significant work in Careline to evaluate risk. This will include creation of chronologies, contact with partner agencies and parents prior to analysing the risk to vulnerable children. This is resource-heavy and time consuming.

	Q1	Q2	Q3	Q4	Total
2014-15	2182	1826	1951	2133	**8092**
2015-16	2204	1908	1376	1765	**7300**
Total Number of Referrals to Children's Social Care 2015/16					

Referrals to Children's Social Care (number / %) by Referring Agency 2015/16						
Agency	**Q1 15-16**	**Q2 15-16**	**Q3 15-16**	**Q4 15-16**	**Q1-4 Total**	**Q1-4 % Total**
Police	679	503	295	472	1949	26.7%
Schools	262	176	205	418	1061	8.8%
Other	154	150	61	178	543	7.4%
Individual- Family	123	172	83	82	460	6.3%
Education services	121	105	109	1	336	10.3%
Health - Other Primary Health Source	117	126	102	194	539	7.4%
Health - A & E	112	121	96	99	428	5.9%
LA Services- Social Care	112	99	70	121	402	5.5%
Not recorded	104	88	65	0	257	3.5%
Other legal agency	93	104	76	63	336	4.6%
Anonymous	75	86	42	63	266	3.6%
LA Services- External	62	40	23	2	127	1.7%
Health Services- Other	55	64	26	1	146	2.0%
LA Services- Other Internal (Excluding Housing)	37	18	66	14	135	1.9%
Health - GP	29	33	16	0	78	1.1%
Housing	29	25	17	29	100	1.4%
Health - HV	15	19	13	0	47	0.6%
Individual- Other	9	8	3	1	21	0.3%
Individual- Acquaintance	7	12	1	4	24	0.3%
Health - School Nurse	2	2	5	0	9	0.1%
Unknown	7	0	0	9	16	0.2%
Individual- Self	0	4	2	9	15	0.2%
Total	**2204**	**1955**	**1376**	**1760**	**7295**	**100.0%**

A significant number of cases referred to Careline do not result in single assessments. The data below indicates that 5709 single assessments were completed in 2015/16 out of 7295 referrals, and a further 4,400 cases that did not progress to a single assessment following background checks and an evaluation of risk. It is not clear how the below data has been impacted by recording issues. This is especially relevant for Q3 figures (891) which seems too

low and coincided with the introduction of Liquid Logic

	Q1	Q2	Q3	Q4	Total	%
2014-15					**6975**	**86.2%**
2015-16	1776	1448	891	1594	**5709**	**78.2%**
Number / % of Referrals to CSC Leading to a Single Assessment						

Improvement Activity:

- Summary review of 2015/16 presented to LSCB 03.11.16
- 2015/16 Performance Management 'Review and Effectiveness' included in LSCB Annual Report (1051/16)

Other Learning Sources:

LSCB Sub Groups:	**Source:**
Learning:	
LSCB Improvement Activity:	

Other (Children / Families / Staff):	**Source:**
Learning:	
Improvement Activity:	
Evidence of Improvement:	

Domestic Homicide Reviews (DHRs)	Source:
Learning:	
Improvement Activity:	
Evidence of Improvement:	

National:	Source:
Learning:	
Improvement Activity:	
Evidence of Improvement:	

LSCB Critical Incident Evidence Committee Process - Flowchart (V06.12.16)

1. Child Death / Serious Incident
WARRANTS REFERRAL TO LSCB CRITICAL INCIDENT EVIDENCE COMMITTEE (CIEC) SUB GROUP

(*Serious Incident Notification form, completed by Manager Safeguarding Unit, returned to OFSTED / Chair CIEC / LSCB Business Manager / Chair LSCB

2. Referral to CIEC Generated – Form CIGSCR1 (CIGCON1 page 3) Completed
(CIGSCR1) LSCB Serious Case Review: Request for CIEC Consideration Form

3. CIGSCR1 referred to CIEC Chair / LSCB Business Manager & LSCB Administrator
(CIGSCR1) form referred to Chair of CIEC, LSCB Business Manager and LSCB Administrator.

4. CIG Chair Liaison with LSCB Independent Chair - Commencement of Case Oversight
Liaison between LSCB Independent Chair & CIEC Chair, Safeguarding Unit Manager upon receipt of CIGSCR1

5. Referral to CIEC for Consideration

1. Chair CIEC notifies LSCB Business Manager and LSCB Administrator that case to be considered at next CIEC
2. LSCB Administrator issues CIG REQUEST FOR INFORMATION (Form CIGINF1) to CIEC Members
3. CIEC members complete and upload completed CIGINF1 to LSCB secure website to file, date as allocated and advised by LSCB Administrator, within 7 days (or by return if CIG within 7 days).

***CIEC members to identify key practitioners (to the date of the incident)**
****CIEC members to facilitate practitioner's attendance at relevant CIEC meeting for discussion of case to support SCR decision making**
(LSCB administrator to be advised of attendees prior to the meeting)

6. Consideration by CIEC:
1. Papers for CIEC meeting are made available from LSCB secure website.
2. Meeting chaired in accordance with standard CIEC agenda for considering Serious Case Reviews (SCR): CIGM1 LSCB CIG SCR CONSIDERATION AGENDA (Part A: Practitioner Review - Part B: Review & CIG Decision)
3. CIEC Recommendation(s) noted.

7. Recommendation of CIEC Referred to LSCB Independent Chair: SCR / Critical Case Review / MA Concise Review / Individual Agency Review / Review not initiated - using LSCB CIG Case Summary (CIGSUM1)
CIG Chair notifies LSCB Independent Chair of CIEC recommendation and rationale for decision

8. LSCB Independent Chair: Challenge / Affirmation of CIG decision
LSCB chair and CIEC chair discuss CIEC recommendation including rationale. LSCB Chair to review, affirm or challenge CIEC recommendation as necessary. LSCB Independent Chair advises CIEC Chair / LSCB Business Manager on decision to initiate SCR (Y/N) or other review with rationale for decision. **Outcome recorded: LSCB CIG Case Summary (CIGSUM1)**

9. Notification to National Panel of Experts on SCRs: (Mailbox.SCRPANEL@education.gsi.gov.uk)

Where the LSCB Chair has decided to **initiate an SCR**, the Chair should give the panel: the name(s) of the reviewer(s) appointed to conduct the SCR.

In cases where the LSCB Chair has decided **NOT to initiate an SCR**, the Chair should:

- let the panel know within 14 days and provide a copy of the local authority's Serious Incident Notification if available (if this is not available, please provide brief anonymised details of the case covering the nature of the incident; ages of the children involved; their relationship with any alleged perpetrator(s); agency involvement with the family; and any criminal investigation);
- provide an explanation why the case does not meet the SCR criteria.

LSCB to refer CIG Summary of Case (CIGSUM1) for review by National Panel on receipt of LSCB chair's response to CIEC recommendations.

LSCB Process: Responding to Cases that May Warrant the Undertaking of a Serious Case Review

CIGCON1

1. Consider Criteria for Undertaking a Serious Case Review (SCR)

Working Together (2015:75):

Cases which meet one of the following criteria i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) **must always** trigger an SCR.

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR. *The final decision on whether to conduct the SCR rests with the LSCB Chair.*

Looked After Children

All cases of a child, that is looked after by the local authority, where abuse or neglect is known or suspected and either the child has died or seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together, are **required** to be referred to the LSCB Critical Incident Group for consideration.

Conducting Reviews on Cases Which Do Not Meet the SCR Criteria

LSCBs must also consider conducting reviews on cases which do not meet the SCR criteria.

If a SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR, or they may choose to commission an alternative form of case review; child death review, review of a child protection incident that falls below the threshold for an SCR, review or audit of practice in one or more agencies (WT2015: 72) so that valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although these cases are not required by statute these cases are important for highlighting good practice as well as identifying improvements which need to be made to local services.

Cases that are considered necessary to be reviewed by the Liverpool Safeguarding Children Board Critical incident Group are required to be referred using the SCR Request for Consideration Form (CIGSCR1) (page 3).

2. Refer Case to the LSCB Critical Incident Evidence Committee:

SCR Request for Consideration Form (CIGSCR1) (p3)

Strategy Meeting: In cases where a strategy meeting is held, chaired by the safeguarding unit, at summary of the meeting attendees should be asked as to whether they consider that the circumstances of the case requires consideration by the LSCB Critical Incident Evidence Committee (CIEC) for the undertaking of a serious case review.

If it is agreed that the case warrants referral to the LSCB CIEC then the Chair of the meeting is responsible for sending the SCR Request for Consideration form to the Chair of the LSCB Critical Incident Evidence Committee (CIEC) and LSCB Business Manager.

Other Cases: If a professional, following review with their agency safeguarding lead, consider that a case requires consideration by the LSCB CIEC to undertake a SCR, agency safeguarding lead should refer a summary of the case using the SCR Request for Consideration form to the Chair of the LSCB Critical Incident Group and LSCB Business Manager.

Where it is considered that a case requires consideration by the LSCB CIEC, to undertake a SCR or other form of review for example a child death review or review of a child protection incident (WT2015; 72) a summary of the case should be referred to the Chair of the CIEC and LSCB Business Manager using the **SCR Request for Consideration Form (CIGSCR1) (page 3)**

The Chair of the CIEC and LSCB Business Manager, following appropriate consultation with the Independent chair of LSCB, will advise the referrer as to whether the case is to be referred to the LSCB CIEC or not. [Reasons for non-referral to the CIEC will be advised].

The final decision on whether to conduct a SCR rests with the LSCB Chair.

3. Response to Cases Referred to LSCB CIEC for Consideration

i) Referral to next monthly CIEC meeting is undertaken by LSCB Admin.

ii) CIEC members are notified of the case and are provided with name, address and date of birth of those involved. CIEC members complete and return Request for Information Forms (CIGINF1) 2013.

iii) Information from settings is considered and decision made as to whether a review, SCR or other, is deemed necessary.

iv) CIEC Decision;

- **SCR agreed**: LSCB SCR Action Plan is implemented.

[If decision to progress with a review is unable to be made, further information may be requested and a further date to meet set.]

- **Review, other than a SCR, agreed**: LSCB Business Manager and LSCB admin will progress as necessary.

- **Review not required**: Decision of the LSCB CIEC is recorded. Agency referrer is notified of the decision by the LSCB Business Manager.

Any CIEC decision to progress / or not by means of a SCR will be notified to the agency referrer by the LSCB Business Manager.

v) All cases notified to CIEC are included on the LSCB CIEC/ SCR spreadsheet for review and oversight as necessary.

LSCB Serious Case Review: Request for CIEC Consideration Form (CIGSCR1)

1. Serious Case Review Criteria for Review

Working Together (2015: 75):

Cases which meet one of the following criteria i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) must always trigger an SCR.

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

FOR COMPLETION IN ALL CASES: Reason(s) for submission of request for CIEC consideration:

2. Summary of case:

3. Name of Child, Young Person / DOB / DOD (if deceased):

4. Name / DOB of significant adults and children:

5. Agency Providing Information:

7. Named Lead / person providing this information:

8. For Cases referred by Agency:

Date Case Reviewed with Agency Safeguarding Lead:

Name and position within agency with whom case reviewed:

9. Date of SCR Request for Consideration Form Completion:

***Boxes expand to fit**

Completed LSCB Serious Case Review: Request for Consideration Forms is to be returned to LSCB via: Jacqueline.Taylor2@liverpool.gov.uk